

# Sample Hospice Certification Form



## PHYSICIAN'S CERTIFICATION OF TERMINAL ILLNESS FOR MEDICARE HOSPICE BENEFIT

Certification/Recertification Statement: For the benefit period of: (first - last date of benefit period),

I certify that \_\_\_\_\_ (beneficiary name) \_\_\_\_\_ is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

I believe this to be true because of the following clinical findings:

(Physician narrative explanation of the clinical findings to support life expectancy of 6 months or less, including guidelines from the Local Coverage Determination (LCD) as applicable.)

\_\_\_\_\_  
(Hospice Medical Director signature)

\_\_\_\_\_  
(date by physician)

\_\_\_\_\_  
(Independent attending physician signature)

\_\_\_\_\_  
(date by physician)

Received verbal certification from Medical Director: Date: \_\_\_\_\_

Received By: \_\_\_\_\_

Received verbal certification from independent attending physician: Date: \_\_\_\_\_

Received By: \_\_\_\_\_

### Attestation Statement:

By signing this certification, the physician, named above, confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient.



Cahaba GBA, LLC A CMS Contracted Intermediary

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